MOVE MORE DUNDEE

Endorsed by WE ARE MACMILLAN. CANCER SUPPORT

REFERRAL FORM

Patient's Name: (insert NHS label)	**Name & position of person referring:**
DOB/CHI:	
Address:	**Base:**
	Telephone:
Tel no:	**Email address:**
GP / Medical Practice	

Aim of referral to MOVE MORE Dundee: (tick all that apply)

to improve quality of life	☐	to combat fatigue	☐	to improve physical function	☐
weight management	☐	to improve fitness	☐	other	☐

Diagnosis

Treatment

Chemotherapy	ongoing	☐	completed	☐
Radiotherapy	ongoing	☐	completed	☐
Biological	ongoing	☐	completed	☐
Hormonal therapy	ongoing	☐	completed	☐
Surgery:	ongoing	☐	completed	☐

Other relevant details:

Past Medical History

Previous MI / Angina / Heart failure	☐
Surgery	☐
Muscle, bone, joint conditions	☐
Diabetes	☐
Respiratory disease	☐
Hearing/visual impairment	☐
Cognitive impairment	☐
Neurological	☐

Other relevant: .....

Patient Consent (data protection act 1988)

I have received the patient information leaflet & understand the information given to me. Yes / No

I agree to the information in this form being passed to the **MOVE MORE** team at **ise** & to being contacted by telephone. Yes / No

I acknowledge that all information will be confidential and held at ise for the purpose of the **MOVE MORE** programme. Yes / No

Signed: Date: